GlobalSelect® Group
International Healthcare Cover

10-24 Employees

Employer's MHD Application & Claims Disclosure Statement

IMG Europe Limited
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GlobalSelect Group is a product underwritten by Sirius International Insurance Corporation (publ) (the "Insurer"). Distributed, managed and administered as agent for and on behalf of the Company, by International Medical Group®, Inc. (IMG®) and IMG Europe Ltd.

The Employer must complete and return this form within 15 days prior to the effective date of coverage. This information will be treated as confidential by the Insurer, International Medical Group (IMG) and IMG Europe Ltd. No coverage will be effective until final approval is given by IMG or IMG Europe Ltd. The current coverage in force should not be cancelled prior to receiving written acceptance of coverage by IMG or IMG Europe Ltd.

Please complete this form and return it to IMG Europe Ltd with the:

- ☐ Individual enrolment forms and copies of current policy schedules/certificates of insurance for each person to be covered.
- ☐ Individual health declaration forms.
- ☐ Cheque payable to "**IMG Europe Ltd** "as a deposit towards the first month's premium (1/12th of estimated annual premium).

Prospective Certificate Holder (The Employer)

Employer/Group/Organisation Name:		Account Contact Person:	
Address:			
City:	County/Region/State:	Postal/Zip Code:	Country:
Telephone: +( ) -	Fax: +( ) -		E-mail:
Proposed Effective Date:	Pay Frequency: ☐ Annual ☐ Semi-annual ☐ Quarterly ☐ Monthly	Currency: ☐£ ☐€ ☐$	Amount of Deposit with Application:
Employer Contribution: _____ Of Eligible Employee Premium _____ Of Dependent Premium			
Total Number of Employees Applying for cover:	Total Number of Employees:	Total Number of Eligible Employees:	

Benefits Applied For

On behalf of the Employer applicant named overleaf as the prospective Certificate Holder, the Employer hereby applies to Sirius International Insurance Corporation (publ). for the following GlobalSelect Group coverages and benefits:

- if cover details for any members/sub groups will be different - please identify individual's area/level of cover and excess on census

(Census Attached? ☐ Yes ☐ No)

Geographical Area Of Cover (Tick one)	☐ **Area 1:** Europe ☐ **Area 2:** Worldwide excluding the USA, Canada, China Hong Kong, Macau, Japan, Singapore & Taiwan ☐ **Area 3:** Worldwide ☐ **Area 4:** Custom Area: ☐ **Mixed, refer to Census**	
GlobalSelect Sub-Plan	☐ **HeadStart** ☐ **Basic** ☐ **Standard** ☐ **Executive** ☐ **Custom Coverage (See attached Schedule)** ☐ **Mixed, refer to Census**	
Medical Excess Level	_____ Per Insured Person, Per Condition, Per Period of Insurance ☐ **Mixed, refer to Census**	
Underwriting	☐ **Medical History Disregarded (MHD) – we confirm eligibility in accordance with the MHD Checklist** **Name of Prior Carrier:**_____	
Optional Additional Covers	**Global Personal Accident Plan** ☐ **Not Applied For** ☐ **One Unit of Cover** ☐ **Two Units of Cover** ☐ **Mixed, refer to Census**	**Global Daily Indemnity Cover – Hospital Income Plan** ☐ **Not Applied For** ☐ **Yes**

Claims Disclosure Statement

The Employer is required to disclose in respect of all persons (Employees and Dependents) to be covered by this Plan. If the answer to any of the following questions is yes, please give details in the space provided. Attach additional pages as necessary. Final rates and cover will be based upon the actual enrolment, including previous provider's cover/terms.

1.	Is any person to be covered under this Plan currently pregnant? If yes, please provide complete details	☐ Yes ☐ No
2.	Participants (employee or dependent) who are or are expected to be absent from work due to work related or non-work related disability on the effective date of coverage.	☐ Yes ☐ No
3.	Participants (employee or dependent) who are or have been pre-authorised or confined to a hospital or medical facility prior to the date of completion of this Statement, or who are suffering from a medical condition whereby they are planning or likely to result in a need for an in-patient hospital stay.	☐ Yes ☐ No
4.	Participants with a history or a current diagnosis or incurred any claims in the past 12 months for Cancer or HIV/AIDS.	☐ Yes ☐ No
5.	Participants currently on a waiting list or contemplating any type of Transplant.	☐ Yes ☐ No

Group Member Details

Please list each person to be covered under this Policy (you may attach a schedule/census if this is more convenient): **Tick if census attached** ☐

Name	Sex	Date of Birth	Nationality	Country of Residence	Insured Type* **EE / S / D / SP**

***Insured Type Key** : Employee (**EE**), Spouse (**S**), Dependent Child - Under 23 if in full time education (**D**), Single Parent/Employee (**SP**) and list all D's

Declaration and Agreement:

Enclosed is payment of 1/12th of the estimated annual premium towards the first month's premium.
The Employer understands:

i. no coverage shall be effective unless and until notified in writing by IMG Europe Ltd that the Employer's application has been accepted by IMG Europe Ltd. for and on behalf of the Insurer,
ii. any such acceptance is at the sole discretion of IMG Europe Ltd. If the Employer's application is accepted, the enclosed deposit will be applied toward payment of the first monthly premium. If the Employer's application is not accepted, IMG's, IMG Europe Ltd's and the Insurer's sole obligation will be to return the deposit premium to the Employer,
iii. as an employer employing persons in foreign jurisdictions, the Employer may be subject to foreign laws with respect to the provision of medical benefits and/or the insurance of those benefits, and agrees that neither the Insurer, nor IMG, nor IMG Europe Ltd. have investigated whether or how the purchase of this insurance complies with the laws of any foreign jurisdiction. The Employer further understands and agrees that Employer is solely responsible for compliance with all applicable foreign laws.

I hereby declare for and on behalf of the Employer, to the best of my knowledge that the information provided and Claims Disclosure Statement above (or as attached) is complete, true and accurate and that nothing has been intentionally and/or negligently omitted. I understand and agree that this declaration will constitute part of the Employer's application and any misrepresentation, failure to provide sought for information or failure to disclose any material facts may result in the contract being void. (If you are in any doubt whether certain facts are material, these should be disclosed).

I further acknowledge and agree that this information may be used by International Medical Group (IMG), IMG Europe Ltd and the Insurer in determining the acceptability of the Employer's group's risk and that the information contained in this form may result in a change of rates quoted on the proposal. We understand that no coverage shall be provided unless specifically agreed to in writing by IMG or IMG Europe Ltd.

Signature of Authorised Employer Representative:_____ Date:_____

Printed Name:_____ Title/Position:_____

This form must be signed by the Company Secretary or equivalent officer

Agent Name: _____ Agent Number:_____